Supreme Court, U.S.
FILED
AUG 14 1995
OFFICE OF THE CLERK

No. 95-66

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

LINCOLN NATIONAL LIFE INSURANCE COMPANY and
EMPLOYERS HEALTH INSURANCE COMPANY,
Petitioners,
v.
ALLEN L. HARDESTER, JR. and BARBARA HARDESTER,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

THERESA L. SOROTA
Health Insurance Association of America
555 13th Street N.W.
Suite 600 East
Washington, D.C. 20004
(202) 824-1600

J. ROBERT GEIMAN*
WILLIAM A. CHITTENDEN III
DOUGLAS J. VARGA
Peterson & Ross
200 East Randolph Drive
Suite 7300
Chicago, Illinois 60601
(312) 861-1400
Counsel for Amicus Curiae, Health Insurance Association of America

* *Counsel of Record*

BEST AVAILABLE COPY

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA 2

REASONS FOR GRANTING THE WRIT 3

I. THE DECISION BELOW CONTRAVENES THE POLICY OF ERISA BY FAILING TO APPLY UNAMBIGUOUS PLAN TERMS IN THEIR ORDINARY AND POPULAR SENSE 5

II. THE DECISION BELOW WILL HARM THE INTERESTS OF ERISA PLAN PARTICIPANTS AND BENEFICIARIES BY INCREASING THE COST OF HEALTH CARE COVERAGE PROVIDED BY COMMERCIAL INSURERS 7

III. THE DECISION BELOW CONTRAVENES THE NATIONAL INTEREST IN PROMOTING ERISA PLANS AND PROTECTING PLAN ASSETS FOR THE BENEFIT OF PARTICIPANTS AND BENEFICIARIES AS A WHOLE 9

CONCLUSION 14

TABLE OF AUTHORITIES

CASES **Page**

Alessi v. Raybestos-Manhattan, Inc.,
451 U.S. 504 (1981) 12

Auto Owners Ins. Co. v. Thorn Apple Valley, Inc.,
31 F.3d 371 (6th Cir. 1994), *cert. denied*,
115 S. Ct. 1122 (1995) 12

Brewer v. Lincoln Nat'l Life Ins. Co.,
921 F.2d 150 (8th Cir. 1990), *cert. denied*,
501 U.S. 1238 (1991) 5

Brewer v. Protexall, Inc.,
50 F.3d 453 (7th Cir. 1995) 5

Bullwinkel v. New England Mut. Life Ins. Co.,
18 F.3d 429 (7th Cir. 1994) 4

Burnham v. Guardian Life Ins. Co. of America,
873 F.2d 486 (1st Cir. 1989) 7, 10, 11

Coble v. Bonita House, Inc.,
789 F. Supp. 320 (N.D. Cal. 1992) 9

Coleman v. Nationwide Ins. Co.,
969 F.2d 54 (4th Cir. 1992), *cert. denied*,
113 S. Ct. 1051 (1993) 12

Curtis v. Noel,
877 F.2d 159 (1st Cir. 1989) 13

Evans v. Safeco Life Ins. Co.,
916 F.2d 1437 (9th Cir. 1990) 5

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101 (1989) 5

Fox Valley & Vic. Constr. Workers Pension Fund v. Brown,
897 F.2d 275 (7th Cir. 1990), *cert. denied*,
498 U.S. 820 (1990) 5

TABLE OF AUTHORITIES

Page

Holmes v. Pacific Mut. Life Ins. Co.,
706 F. Supp. 733 (C.D. Cal. 1989) 9, 10

Hozier v. Midwest Fasteners, Inc.,
908 F.2d 1155 (3d Cir. 1990) 10

Kirk v. Provident Life & Acc. Ins. Co.,
942 F.2d 504 (8th Cir. 1991) 4

LeFebre v. Westinghouse Elec. Corp.,
747 F.2d 197 (4th Cir. 1984) 13

Mertens v. Hewitt Assocs.,
113 S. Ct. 2063 (1993) 12

Moore v. Metropolitan Life Ins. Co.,
856 F.2d 488 (2d Cir. 1988) 10

Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees,
740 F.2d 454 (6th Cir. 1984), *cert. denied*,
469 U.S. 1109 (1985) 9

Morse v. Stanley,
732 F.2d 1139 (2d Cir. 1984) 13

Nazay v. Miller,
949 F.2d 1323 (3d Cir. 1991) 9, 13

Peckham v. Gem State Mut. of Utah,
964 F.2d 1043 (10th Cir. 1992) 12

Pohl v. National Benefits Consultants, Inc.,
956 F.2d 126 (7th Cir. 1992) 12

Rueda v. Seafarers Int'l Union of North America,
576 F.2d 939 (1st Cir. 1978) 11

Shaw v. Delta Air Lines, Inc.,
463 U.S. 85 (1983) 12

TABLE OF AUTHORITIES

Page

STATUTES

29 U.S.C. § 1001(b) 12

29 U.S.C. § 1022(a)(1) 5

29 U.S.C. § 1104(a)(1)(A) 13

29 U.S.C. § 1104(a)(1)(B) 13

MISCELLANEOUS

B. HARTNETT & I. LESNICK, THE LAW OF LIFE & HEALTH INSURANCE (Matthew Bender 1995) 8

W. MEYER, LIFE & HEALTH INSURANCE LAW (1972) 8

J. Williams, *Construction and Application of Provision in Health or Hospitalization Policy Excluding or Postponing Coverage of Illness for Which Medical Care or Treatment Was Received Within Stated Time Preceding or Following Issuance of Policy,* 95 ALR 3d 1290 (1979) 8

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

No. 95-66

LINCOLN NATIONAL LIFE INSURANCE COMPANY and
EMPLOYERS HEALTH INSURANCE COMPANY
Petitioners,
v.
ALLEN L. HARDESTER, JR. and BARBARA HARDESTER
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

The Health Insurance Association of America ("HIAA") submits this brief in support of the Petition of Lincoln National Life Insurance Company and Employers Health Insurance Company (collectively, "Lincoln National") for a writ of certiorari in this case. Both the Petitioners and the Respondents have consented to the filing of this brief. Correspondence confirming such consent has been filed with the Clerk of this Court.

INTEREST OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

The HIAA submits this brief to support the interests of its members and other parties with a stake in the viability and affordability of group health insurance contracts governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. The HIAA is the largest health insurance trade association in the United States and represents the interests of approximately 230 member companies, including many of the leading health insurers in this country. HIAA members currently provide health insurance coverage to over fifty million Americans, many of whom are participants in and beneficiaries of ERISA-regulated benefit plans.

The Fourth Circuit Court of Appeals' *en banc* decision in this matter is of great concern to the HIAA and its members because it undermines the intended operation of preexisting condition provisions contained in the vast majority of health insurance contracts issued in the United States. By negating the force and effect of a standard preexisting condition provision, the Fourth Circuit's decision renders meaningless the actuarial assumptions on which the Petitioners in this case — and indeed virtually all commercial health insurers — rely in issuing health insurance contracts. In short, the Fourth Circuit's erroneous interpretation of a standard contractual provision will require Lincoln National to assume obligations not contemplated at the time the subject contract was issued. If allowed to stand, the Fourth Circuit's decision similarly could undermine ERISA-governed contracts across the board.

As a trade association for this nation's commercial health insurers, the HIAA also is concerned about the effect of the Fourth Circuit's decision on its members' relationships with the other principal ERISA entities: employers who sponsor group health plans, and the participants and beneficiaries of those plans. If left unchecked, the Fourth Circuit's decision ultimately will filter down to employers, who will be asked to pay higher premiums to re-

flect an increase in potential liability for claims formerly excluded under standard preexisting condition provisions. As with most products, these increased costs will be passed on to the ultimate "consumers," ERISA plan participants and beneficiaries, who either will be required to contribute a greater percentage of premium costs or will see a decline in available benefits in order to restrain plan costs. In a highly competitive market in which employers strenuously attempt to obtain employee health care coverage at the lowest possible cost, it is clear that by saddling commercial health insurers with unanticipated liability for claims involving preexisting conditions, the Fourth Circuit's decision will cause all players in the employee benefits arena to carry an increased burden in the ongoing battle to contain health care costs.

The HIAA submits that the ramifications of the Fourth Circuit's decision in this case extend well beyond the interests of the immediate parties and, therefore, urges this Court to grant the Petition for a Writ of Certiorari.

REASONS FOR GRANTING THE WRIT

The Fourth Circuit's decision in this case warrants review by this Court not only because it evinces a fundamental misapprehension of the proper construction of express terms of ERISA-governed group insurance contracts, but also because the decision presages a significant shift in the risks and costs associated with ERISA plans generally.

In its decision, the Fourth Circuit essentially held that the preexisting condition exclusion contained in Lincoln National's contract may be enforced only if an accurate diagnosis of the precise condition is rendered prior to a participant or beneficiary's effective date of coverage. Pet.App. 23a-26a.[1] This conclusion is clearly at odds with both the plain language of the provision itself and the holdings

---

[1] References to the Appendix to Petitioners' Petition for a Writ of Certiorari, filed with this Court on July 14, 1995, are designated "Pet. App."

reached by two other Circuit Courts of Appeal addressing similar provisions contained in ERISA-governed plans. *See Bullwinkel v. New England Mut. Life Ins. Co.*, 18 F.3d 429 (7th Cir. 1994); *Kirk v. Provident Life & Acc. Ins. Co.*, 942 F.2d 504 (8th Cir. 1991). The court's conclusion violates established, fundamental principles guiding the interpretation and construction of ERISA plan terms. The legal deficiencies in the Fourth Circuit's holding, however, pale in comparison to the deleterious effect the decision undoubtedly will have on the intended recipients of ERISA's protections.

The decision below will substantially increase the risks assumed by commercial health insurers for healthcare coverage provided to the participants and beneficiaries of ERISA-regulated benefit plans. If required to provide benefits for medical expenses historically excluded from coverage, health insurers will have no choice but to increase the cost of coverage to meet the newly-imposed liabilities, or decrease other previously-available types or amounts of benefits. These adjustments ultimately will filter down through employers and come to rest on the shoulders of ERISA plan participants and beneficiaries.

The decision below also will have a negative effect on two important goals of ERISA: the promotion of employer-provided welfare benefit plans, and the safeguarding of plan assets in the interests of all plan participants and beneficiaries. The financial integrity of ERISA plans is crucial to the proper functioning of an employer-based health care benefits system; if that integrity is shaken by unforseen liabilities like those at issue here, the entire system will feel the effect. Moreover, as in any environment involving allocation of a fixed commodity (in this case, health care), the distribution of ERISA plan benefits must be accomplished with a view toward the continuation and maintenance of the plan itself. The Fourth Circuit's ruling in this case fails to balance the interests of the individual claimant against those of all other plan participants and beneficiaries.

The Fourth Circuit's decision is important because it raises fundamental questions as to the proper construction, interpretation, and application of ERISA plan terms. The decision also affects the continued viability of ERISA plans generally. Accordingly, this Court should grant the Petition for a Writ of Certiorari and accept this case for review.

I. THE DECISION BELOW CONTRAVENES THE POLICY OF ERISA BY FAILING TO APPLY UNAMBIGUOUS PLAN TERMS IN THEIR ORDINARY AND POPULAR SENSE

The interpretation and construction of the terms and provisions of ERISA-regulated insurance contracts must be governed by a uniform body of federal substantive law. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989). This body of federal law is drawn from the language of the statute itself and, where ERISA is silent, from the federal common law of ERISA as developed by the federal courts. *Fox Valley & Vic. Constr. Workers Pension Fund v. Brown*, 897 F.2d 275, 281 (7th Cir. 1990), *cert. denied*, 498 U.S. 820 (1990). It is by now well-settled that the federal common law of ERISA embodies the principle that plan terms must be given their plain, natural meanings and must be interpreted in an ordinary and popular sense as would a person of average intelligence and experience. *E.g., Brewer v. Protexall, Inc.*, 50 F.3d 453, 457 (7th Cir. 1995); *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990). This established principle of ERISA plan interpretation is derived, in part, from the ERISA statute itself, which requires plan administrators to furnish plan descriptions "written in a manner calculated to be understood by the average plan participant." 29 U.S.C. § 1022(a)(1); *see Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991).

The decision below pays lip service to these general principles, acknowledging that the court was bound to "enforce the policy's plain language in its ordinary sense." Pet. App. 23a. Nevertheless, the court's holding does violence

to that principle by failing to apply plain, unambiguous terms as written to the facts before it. Any reasonable reading of the plan terms at issue in this case can only lead to the conclusion that no coverage was available under the Lincoln National contract. The plan's definition of the terms "preexisting condition" and "sickness" is written in a manner easily understandable by an average plan participant and clearly indicates that no benefits are available for medical services relating to a "sickness" (defined as a disturbance in the body's function or structure that causes physical signs and/or symptoms and which, if left untreated, would result in a deterioration of the health state of the body's structure or system) if, prior to the participant's effective date of coverage, he or she receives medical attention (defined as "care, treatment, services, medication, diagnosis or consultation") for that sickness. Pet. App. 23a. The facts of this case confirm that, at the very least, Respondent Barbara Hardester received care or treatment for a disturbance in her left breast prior to the effective date of her coverage. Pet. App. 14a-17a. Accordingly, under the plain terms of the foregoing provisions, the medical treatment directed to the problems with her left breast after the effective date of coverage fall within the preexisting condition exclusion. There simply is no justification for the court's additional requirement that the particular cause of the physical problem must be accurately diagnosed prior to the effective date of coverage for the preexisting condition exclusion to apply.

ERISA requires that plan descriptions be written in an understandable fashion so that all involved in the benefits process (insurers, employers, plan administrators, and plan participants and beneficiaries) will know precisely what benefits are provided under the subject plan. This worthwhile goal is defeated if courts refuse to apply express provisions in accordance with the common understanding of the language employed. In this respect, the First Circuit has made the following observation:

> Notwithstanding the ennobling purposes which prompted passage of ERISA, courts have no right to torture language in an attempt to force particular results or to convey delitescent nuances the contracting parties neither intended nor imagined. To the exact contrary, straightforward language in an ERISA-regulated insurance policy should be given its natural meaning.

Burnham v. Guardian Life Ins. Co. of America, 873 F.2d 486, 489 (1st Cir. 1989).

The preexisting condition exclusion at issue here is clear, unambiguous, and easily applied. The Fourth Circuit's failure to apply this provision in a straightforward manner may have benefitted Respondents, but at the expense of the certainty and uniformity mandated by ERISA. In light of the decision below, the various parties involved in the ERISA benefits arena — insurers providing health insurance contracts to ERISA plans, employers sponsoring and/or self-funding ERISA plans, ERISA plan administrators, and ERISA plan participants and beneficiaries — are left wondering how a given court will interpret express plan terms. This inevitably will lead to confusion as to precisely what benefits may be available under an ERISA plan. This Court should take this opportunity to confirm that federal courts called upon to interpret and construe terms in an ERISA-governed plan must do so in an ordinary and popular sense, to the end that all those with an interest in ERISA plan benefits will be able to gauge the actual benefits available to plan participants and beneficiaries.

II. THE DECISION BELOW WILL HARM THE INTERESTS OF ERISA PLAN PARTICIPANTS AND BENEFICIARIES BY INCREASING THE COST OF HEALTH CARE COVERAGE PROVIDED BY COMMERCIAL INSURERS

Insurance policies generally provide coverage only for losses sustained while the policies are in effect. Health

insurance contracts, like other forms of insurance, typically are designed to provide benefits only for medical conditions, sicknesses, or illnesses arising after the effective dates of coverage under the contracts. Accordingly, these contracts often contain express provisions precluding coverage for preexisting conditions. W. MEYER, LIFE & HEALTH INSURANCE LAW, § 17.1 at 548 (1972). The motivation behind these provisions is clear: health insurers seek to decrease the cost of their products by avoiding the "economic implications of insuring the health of persons already suffering from illnesses which would otherwise be covered under the insurer's policy." J. Williams, *Construction and Application of Provision in Health or Hospitalization Policy Excluding or Postponing Coverage of Illness for Which Medical Care or Treatment Was Received Within Stated Time Preceding or Following Issuance of Policy*, 95 ALR 3d 1290, 1292 (1979). The majority of health insurance policies issued in this country contain some form of preexisting condition provision excluding or limiting benefits for medical conditions predating the effective date of coverage. B. HARTNETT & I. LESNICK, THE LAW OF LIFE & HEALTH INSURANCE, § 6.07[3] at 6-119 (Matthew Bender 1995).[2]

The preexisting condition exclusion at issue in this case was designed to relieve Lincoln National from liability for medical expenses arising out of conditions for which the participant or beneficiary obtained treatment or consultation prior to his or her effective date of coverage. By negating the effect of such provisions, the Fourth Circuit's decision disrupts the risk and cost calculations underlying the issuance of the subject health insurance contract. The aggregate effect of this decision will cause substantial harm to those for whose benefit ERISA was designed. Faced with liabilities for preexisting conditions not contemplated at the

---

[2] While most policies contain preexisting condition exclusions, in some cases they apply only to late enrollees. In addition, a majority of states has enacted laws prohibiting insurers from applying preexisting condition exclusions to certain employees who have maintained continuous health coverage.

time their contracts were issued, commercial insurers providing health care coverage to ERISA plans will be forced either to charge higher premiums for the same level of prior benefits, or to provide a decreased level of benefits for participants and beneficiaries. Employers offering such plans to their employees similarly will be forced to decide whether to require increased premium contributions from employees or to reduce available benefits. Invariably, the price of forcing commercial insurers to cover preexisting conditions will be paid by ERISA plan participants and beneficiaries. The stated goals of ERISA look unfavorably upon such a result.

III. THE DECISION BELOW CONTRAVENES THE NATIONAL INTEREST IN PROMOTING ERISA PLANS AND PROTECTING PLAN ASSETS FOR THE BENEFIT OF PARTICIPANTS AND BENEFICIARIES AS A WHOLE

A primary purpose of ERISA is to encourage private sector employers to establish and maintain employee benefit plans, and to secure the stability of these plans once established. *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733, 735 (C.D. Cal. 1989). ERISA, however, does not *require* employers to establish benefit plans; this decision is left entirely to the employer's discretion. *See, e.g., Nazay v. Miller*, 949 F.2d 1323, 1329 (3d Cir. 1991). Moreover, ERISA has no bearing on an employer's decision as to the type or amount of benefits included in a plan. *See, e.g., Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees*, 740 F.2d 454, 456 (6th Cir. 1984), *cert. denied*, 469 U.S. 1109 (1985); *Coble v. Bonita House, Inc.*, 789 F. Supp. 320, 321 (N.D. Cal. 1992) ("ERISA does not mandate the provision of health insurance coverage by employers, any particular type of coverage that must be provided, or any changes in the scope of coverage").[3]

---

[3] The flexibility afforded employers in deciding what benefits to offer under ERISA-regulated plans is particularly important in the context of medical coverage. For example, in denying a claim by retirees

An employer offering employee welfare benefits is free to establish the type and amount of medical benefits it will provide. Given the voluntary nature of ERISA plan sponsorship, the cost of providing such coverage clearly is relevant; indeed, in seeking to promote such plans through ERISA regulation, Congress recognized that it must take into account additional costs from the employer's standpoint. *See Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1160 (3d Cir. 1990); *Holmes*, 706 F. Supp. at 735.

This point is made abundantly clear in *Burnham v. Guardian Life Ins. Co. of America*, 873 F.2d 486 (1st Cir. 1989). In *Burnham*, the Court of Appeals for the First Circuit held that a group life insurer correctly denied life insurance benefits to the plaintiff because her decedent was not an eligible "full-time employee" under the terms of the plan. The court rejected the plaintiff's claim that a literal construction of the plan contravened ERISA's policy to promote the interests of beneficiaries, stating as follows:

> Safeguarding the interests of employees as a whole is a multifaceted endeavor. Any time coverage is less than universal, line-drawing becomes a necessary evil. . . . [T]he contracting parties (employer and insurer) had the right to plot the line as they saw fit, so long as the coordinates were rationally related to meet a lawful objective of the plan.

Id. at 490. The court further disposed of the plaintiff's argument that application of the policy language was improperly applied to her:

> It cannot validly be argued that all ERISA plans must pass an "as applied" test. *Almost by definition, group plans require generalization. They focus*

---

that their employer could not change their medical benefits, the Second Circuit noted that limiting an employer's right to change medical plans risked decreasing protection for future employees and retirees due to the realities of inflation and changes in medical practices and treatments. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988).

> *on verifiable benchmarks, sparing the need for in-depth investigation of the circumstances of each and every claim.* That a seeming inequity may result on occasion is not fatal to the plan's legitimacy: after all, as we said in an earlier ERISA case, "*the necessity to draw hard boundary lines, inevitably adversely affects some individuals who find themselves on the wrong side of a line.*"

Id. (emphasis added) (quoting *Rueda v. Seafarers Int'l Union of North America*, 576 F.2d 939, 942 (1st Cir. 1978)).

The same reasoning holds true in this case. In providing health care coverage for the plan in which Respondents participated, Lincoln National drew a line with respect to available benefits for treatment of preexisting conditions. This case arose simply because, unfortunately, Respondents found themselves on the wrong side of the line. It is clear, however, that this line (and indeed every other limitation of the Plan that made coverage anything less than universal) reduced the costs of the insurance to Respondents' employer and, therefore, promoted the maintenance of the plan for all employees. If no such limitation were present, obviously the cost of providing the insurance would have increased.

Furthermore, in applying the preexisting condition exclusion, Lincoln National simply upheld a line drawn for the purpose of reducing the risk and cost associated with conditions predating coverage. The continued availability of benefits for all participants in the plan is affected by payment of claims beyond those contemplated in the insurance policy. The reason is simple: premiums charged for insurance naturally will rise in proportion to the amounts paid for claims. In other words, excessive claims experience ultimately results in a decrease or elimination of Plan benefits (or a corresponding increase in employer/employee premium contributions) as these costs are passed through.

The Fourth Circuit's decision in this case at first glance

may appear to comport with ERISA's stated objective "to protect the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); *see* 29 U.S.C. § 1001(b). This Court, however, has noted the need to balance the "tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing pension costs." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981); *see Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063, 2072 (1993) (noting concern over indirectly exposing ERISA plans to liabilities that would increase plan costs).

A number of Circuit Courts of Appeals, including the court below, similarly have recognized that protecting the financial integrity of employer-provided welfare plans is a primary goal of ERISA. *See Auto Owners Ins. Co. v. Thorn Apple Valley, Inc.*, 31 F.3d 371, 375 (6th Cir. 1994), *cert. denied*, 115 S. Ct. 1177 (1995); *Coleman v. Nationwide Ins. Co.*, 969 F.2d 54, 60 (4th Cir. 1992), *cert. denied*, 113 S. Ct. 1051 (1993); *Peckham v. Gem State Mut. of Utah*, 964 F.2d 1043, 1050 n.12 (10th Cir. 1992); *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992). The financial integrity of ERISA-governed employee welfare benefit plans clearly is at stake as a result of the ruling below. This decision will expose commercial health insurers to liability for preexisting conditions and thereby force them to assume risks not anticipated at the time their products were offered for sale and for which no premium was received. Because this broad level of increased cost naturally will filter down to — and be absorbed by — employers, participants, and beneficiaries, the Fourth Circuit's decision contravenes fundamental ERISA policy. *See, e.g., Auto Owners*, 31 F.3d at 375 (construing ERISA plan's coordination of benefits provision "to comply with a primary goal of ERISA, which is to safeguard the financial integrity of qualified plans by shielding them from unanticipated claims"); *Coleman*, 969 F.2d at 60 (refusing recovery of health insurance benefits by plan beneficiary following employer's failure to pay required premium and noting that

"[t]he financial integrity of a group health insurer could be quickly compromised if courts compelled the insurer to assume risks for which no premium was ever paid"). Indeed, as the Third Circuit has observed, failure to apply plan terms and limitations as written prejudices the plan as a whole and deprives employers and participants "of an important weapon in their joint battle against rising healthcare costs." *Nazay v. Miller*, 949 F.2d 1323, 1338 (3d Cir. 1991).

The tension between assuring receipt of benefits by ERISA plan participants and beneficiaries and protecting plan assets from undue financial burden also is informed by the statutory duties of an ERISA plan administrator. ERISA requires an individual acting in this capacity to discharge his or her duties with due regard for *both* the interest in providing benefits to participants *and* the interest in defraying reasonable expenses of plan administration. 29 U.S.C. § 1104(a)(1)(A). In addition, the administrator must discharge his or her duties with the care, skill, prudence and diligence that a prudent person would use under the circumstances. *Id.*, § 1104(a)(1)(B). Consequently, in making benefit determinations, the administrator of an ERISA plan must strike a balance between the interests of a claimant beneficiary and the plan itself. *See, e.g., LeFebre v. Westinghouse Elec. Corp.*, 747 F.2d 197, 207 (4th Cir. 1984) ("A trustee has the obligation to guard the assets of the trust from improper claims, as well as the obligation to pay legitimate claims"); *Morse v. Stanley*, 732 F.2d 1139, 1145 (2d Cir. 1984) ("The trustee must deal even-handedly among [the beneficiaries], doing his best for the entire trust looked at as a whole"); *see also Curtis v. Noel*, 877 F.2d 159, 162 (1st Cir. 1989).

Health insurance contemplates an allocation of risk and cost based on historical patterns of claim liability. It also implicates a fundamental trade-off between product affordability and universal access to health care. As with any product, the cost of health insurance must rise if additional benefits are guaranteed. By forcing health insurers

to provide coverage for preexisting conditions clearly excluded by the terms of their plans, the decision below will alter the benefits available to a vast number of ERISA plan participants and beneficiaries. The fallout from this decision will extend to employer decision-making in terms of the establishment and maintenance of employee welfare benefit plans, and will affect the financial viability of existing plans. Given the competing interests represented in ERISA, this Court should recognize the dangers inherent in the decision below and accept this case for review.

CONCLUSION

For the reasons set forth above, the Health Insurance Association of America supports the Petition for a Writ of Certiorari in this case.

Respectfully submitted,

THERESA L. SOROTA
Health Insurance Association of America
555 13th Street N.W.
Suite 600 East
Washington, D.C. 20004
(202) 824-1600

J. ROBERT GEIMAN*
WILLIAM A. CHITTENDEN III
DOUGLAS J. VARGA
Peterson & Ross
200 East Randolph Drive
Suite 7300
Chicago, Illinois 60601
(312) 861-1400
Counsel for Amicus Curiae,
Health Insurance Association of America

* *Counsel of Record*

August 11, 1995